Summer 2017
Achieve Camps
Returning camper registration

Camp is limited to 40 campers
July 25-29 for campers ages 8-102

Registration Information

Camper Name _____ Nickname? _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Email _____

Date of Birth _____ Age _____ Gender: Male / Female

Disability Type(s) _____

T Shirt size _____

Who will be paying for camp? (ie cash, cdc)_____

Legal Guardian(s) Name_____

Address_____

City _____ State _____ Zip Code _____

Home Phone _____Cell Phone _____Work Phone _____

Email _____

Preferred Contact Method: **Phone** or **Email** (please circle)

Camper Information

Has any camper abilities or needs changed from last year?

Medical Information

Medical Insurance: please attach a copy of the insurance card(s) with front and back views.

Is camper covered by medical/hospital insurance? No / Yes (if yes, fill out information below)

Insurance Company _____

Policy Number _____

Insurance Company Address _____

Phone _____

Name of Policy Holder _____

Relationship _____

Emergency Contact Information: if legal guardian listed above cannot be reached or is not the primary emergency contact

Name _____ Relationship _____

Home Phone _____ Cell Phone_____ Work Phone _____

I have read this application and give permission for _____ to attend Camp Bighorn's Achieve Camps and engage in all activities except as noted. This health history, medication report is complete and correct to the best of my knowledge. I give Camp Bighorn permission to administer prescribed medication(s), over-the-counter medications and first aid; to seek medical treatment, including x-rays, hospitalization, or tests as needed; and to provide nursing care while camper is at camp. I agree that Camp Bighorn can arrange for necessary transportation related to medical needs. I understand and agree to abide by any restrictions placed on participations of camp ac activities.

Legal Guardians Signature _____

Relation to camper _____

Date _____

Cost of Camp $295

5% off if they register (paperwork and deposit) by March 1st.
An additional 5% if they also pay in full by March 1st.
An additional 5% off for family members

Please return registration by July 1 Thank you

Mail Registrations:
Camp Cost $295 checks to be payable to Camp Bighorn
1850 MT HWY 135
Plains, MT 59859

406-826-3144
www.campbighorn.com

camp Bighorn

Camp Bighorn Liability Release

BY SIGNING THIS FORM, I hereby acknowledge the inherent risks involved with outdoor adventure and ropes course activities. I do hereby voluntarily participate in the programs offered. I and the participant signed below release and discharge Camp Bighorn from all action that they as a participant, their heirs, guardians, and legal representatives now have or may hereafter have for injury or damages sustained. I acknowledge that I have carefully read this agreement and I give Camp Bighorn permission to use any photo or video of myself or my child for Camp Bighorn publications or promotional advertising,unless otherwise requested. I release my right to any kind of remuneration for said photos or videos.

_____

Participant's Name

_____

Adult Participant OR Signature of Parent or Guardian (if participant is a minor)

_____

Name Printed

_____

Date

Achieve Camps Medication Report

BRING THIS FORM TO CAMP enclosed in a GALLON SIZE zip-lock bag with all MEDICATION

Camper Name _____

Camp Dates _____ **Page** _____ **of** _____

SIGNATURE REQUIRED _____

Medication Report must match dosage sent. All over the counter medication must be sent for your child. This includes, tylenol, etc. NO medications are provided.

For Nurse Only
Do Not Write In Area Below

Medication 1	Dosage	√	Time	Day 1	Day 2	Day 3	Day 4	Day 5
	_____ mg		8:00 AM					
			12:00 PM					
			3:00 PM					
			6:00 PM					
PARENTS Please VERIFY the number of pills sent	___ PILLS		9:00 PM					
			PRN					
Medication 2	**Dosage**	**√**	**Time**	**Day 1**	**Day 2**	**Day 3**	**Day 4**	**Day 5**
	_____ mg		8:00 AM					
			12:00 PM					
			3:00 PM					
			6:00 PM					
PARENTS Please VERIFY the number of pills sent	___ PILLS		9:00 PM					
			PRN					
Medication 3	**Dosage**	**√**	**Time**	**Day 1**	**Day 2**	**Day 3**	**Day 4**	**Day 5**
	_____ mg		8:00 AM					
			12:00 PM					
			3:00 PM					
			6:00 PM					
PARENTS Please VERIFY the number of pills sent	___ PILLS		9:00 PM					
			PRN					
Medication 4	**Dosage**	**√**	**Time**	**Day 1**	**Day 2**	**Day 3**	**Day 4**	**Day 5**
	_____ mg		8:00 AM					
			12:00 PM					
			3:00 PM					
			6:00 PM					
PARENTS Please VERIFY the number of pills sent	___ PILLS		9:00 PM					
			PRN					
Medication 5	**Dosage**	**√**	**Time**	**Day 1**	**Day 2**	**Day 3**	**Day 4**	**Day 5**
	_____ mg		8:00 AM					
			12:00 PM					
			3:00 PM					
			6:00 PM					
PARENTS Please VERIFY the number of pills sent	___ PILLS		9:00 PM					
			PRN					

ALL MEDICATIONS MUST BE IN THEIR ORIGINAL CONTAINERS